everything that his various specialists could teach him, and some very skilled and experienced surgeons, physicians, and other specialists spent periods in our hospital. From all of them Catford insisted on being brought up to date; and he was not only a willing but an able pupil.

"We've got to get him to relax for some hours of the day or he'll do himself and all of us in," said Jonah at an informal conference of the officers. We had all become honorary members of the Ibadan Recreation Club, but the colonel was only with difficulty persuaded to have a siesta from 2-4 pm and go to the club from 4-7 pm. Our day began at 6-7 am. Finally I offered to teach him golf in 30 minutes. He had played tennis, but never golf. But he bought six basic clubs and submitted himself to tuition. He quickly absorbed the idea of the straight left arm, the backhand blow, watching the back of the ball, and the slow and graceful swing; and he soon came to enjoy the game. It was a great relief to all concerned when the previous intensity for medical instruction was partly abated in favour of golf. He politely declined an offer from another officer to teach him snooker.

What a man

In looking after the best interests of his unit Catford spared no trouble. He entertained not only handsomely but with insight and discretion. One "very big master" was due to visit us. Who but Catford would have found out that he was not fit to talk to until he had downed two pink gins? But so it was; and the two pink gins were

ready and waiting; and the unit benefited enormously from the good will thus engendered.

It was a happy unit thanks to the energy, insight, and benevolence of a very fine man. Throughout his life he was a very loyal and active member of the Church of England. He was devoted to art, literature, and classical music. He said how much he loved the sound of a well trained male voice choir.

He was loved by his patients; he had a full and happy family life; and after serving in west Africa he went to the 1944 invasion of Europe in charge of the first field hospital crossing over on D + 3 day. He told me modestly that that part of his war was "quite exciting"—not at all like our time in Ibadan. He went on to become assistant director of medical services for the Normandy and later the Belgian-South Holland area, for which services he received the OBE (Mil). He was promoted to full colonel. On his 50th birthday, on the seventh hole at the Ibadan golf course, he stopped himself when about to play a shot and declared to me: "I'm 50 today; and I have this moment decided what I am to do with the rest of my life." He told me there and then that he would give up general practice and set up in Harley Street. I am confident that he would have done well; but his health and family considerations kept him in Torquay until, after the death of his wife, he retired to live with his daughter, Audrey, in Quidhampton near Salisbury. He lived to be 90. I met him three times after the war ended. He loved to reminisce about Ibadan, and about his days at Marlborough, Cambridge, and Barts; and the time was never long enough to exhaust his enthusiasm for the sheer joy of living and rejoicing in old friendships. What a man he was—and what a good doctor he must have been.

For Debate . . .

Efficiency savings or financial cuts: some morals from Birmingham

M J S LANGMAN

The impact of cash limits on the National Health Service (NHS) has been severe. Unexpected demands or underfunded pay or price rises put pressures on those limits. Health authorities, worried that overspending may put them in breach of the law, may resort to hasty and arbitrary cuts in services to patients. Unfortunately, cuts by one district can all too easily cause unexpected clinical demands on adjacent districts, which understandably have not budgeted for them, thus putting pressures on their cash limits. Birmingham has been suffering from this unwelcome phenomenon.

Each year the government decides in its autumn expenditure review how much money will be allocated to ministries for the next financial year. The sums allocated set the cash limits for those departments, and for the year 1987-8 the Department of Health and Social Security (DHSS) and the Welsh Office expect to receive over £18 billion for the NHS in England and Wales. Over £4 billion will be

spent on family practitioner services, which, incidentally, are not strictly cash limited like the hospital and community health services. Most of the remaining £14 billion is distributed through regional health authorities to district health authorities, which are responsible for providing hospital and community health services for their local populations, which range from under 100 000 to over 400 000.

Tight budgets mean leaner services

Large though these national sums are, by the time district health authorities and units receive their "cash limits," and even if they get extra funds for certain specialist activities such as organ transplantation, the money is often inadequate for the services that hospitals should be providing. Presumably the government expects tight budgets to make the NHS's restructured, accountable management run leaner and more efficient services, with the identification and elimination of wasteful practices. The efficiency savings then bridge the gap between cash limits and the cost of the service to the patients. That, at least, is the theory of introducing the stimulating environment of "commercial management" in the NHS. There are, however, at least three possible fallacies in this approach.

Firstly, the demand for efficiency savings may in practice be imposed when the savings are not there to be made or—with the same effect—the budgetary allocation may be too small.

Secondly, in our bracing competitive climate a company that supplies goods at too high a cost loses its market share and is replaced by another that is more efficient—for example, because its production methods are faster and cheaper. The NHS, however, operates in a world of fixed financial allocations and so the reduction in service provided by one installation, equivalent to commercial closure, offers no market opportunity to another NHS service provider. It simply imposes an unfunded workload because patients untreated in one place have to be dealt with elsewhere as health authority boundaries are artificial and doctors are free to refer patients where they wish.

Thirdly, if an institution is recognised as pre-eminent in providing services demands will be made to use them and the patients referred will often present complex problems and thus be expensive to treat.

Let us examine the effects of this policy in Birmingham, a city arbitrarily divided into five health districts and the site of the single medical school in the West Midlands. The plight of Birmingham Central Health Authority, which houses the medical school, is illustrative.

Efficiency savings

Efficiency savings are being demanded in the central district just as elsewhere, and, as elsewhere, with apparently little or no logical justification beyond the belief that savings are to be made. That such savings might be requested would be tolerable to those who work in the service if they were the only savings to be sought. They are not. Firstly, the government's consistent policy of refusing to fund fully nationally agreed pay awards means that differences have to be found from local budgets. Secondly, the costs of essential equipment and drugs rise inexorably but the DHSS fails to make full allowance for them. Thus the agreed index for standard drug costs in the health service rose by some 18% last year, but extra funding to cover this increase was only 3.5%. So we have less money available for other purchases. In such circumstances is it surprising that nearly 20% of all hospital beds in the Queen Elizabeth Hospital are 50 years old, making simple nursing and resuscitation procedures more difficult than is necessary?

Consequences of restricting services

In attempting to meet budgetary constraints hospital managers inevitably have to restrict services. Demand for those services, however, usually persists, and the consequences are visited on others. Thus a year ago medical beds were closed in the East Birmingham Health Authority. As almost all medical admissions are of patients needing emergency care they have to be found room elsewhere. In this case the workload of the General Hospital in the central district increased: this inevitably resulted in (unfunded) expenditure to meet the unlooked for extra work.

Proposals have been made to close beds for dermatological patients in the central district (table). This will inevitably increase the workload—and therefore its costs—at the Skin Hospital, but this lies in the West Birmingham Health Authority. A potential saving in the central district will therefore mean greater costs for its western neighbour. Similar consequences apply to most closures being contemplated in Birmingham. Thus the Queen Elizabeth Hospital, in the central district, proposes to close—temporarily it is hoped—some 70 beds, not because they are unnecessary but to reduce the workload by 10%. Apart from contemplating the closure of dermatology beds the General Hospital's management is also proposing (inter alia) to restrict orthopaedic procedures, with the result that the waiting list for hip replacement operations could rise by 80%.

Consequences of recognised excellence

The teaching institutions of the central district have long been accepted as offering high standards of service and so have attracted a high referral rate of patients from surrounding hospitals. Some of this workload is acknowledged and funded by special allocations, but some, probably most, is not. Apart from the greater number of patients the cost of caring for them is above average because they require complex nursing procedures, investigations, and treatments. Even when a service receives special allocation the funding level may be inadequate. Thus a special allocation is received for patients requiring chronic ambulatory peritoneal dialysis—a nationally recognised need with a target number of patients required to be treated in each regional authority. At present the Queen Elizabeth Hospital receives funding for some 40 patients but treats three times as many. The cost can no longer be afforded within the budget and so some patients will have to be discharged. If they are not taken on elsewhere they will die, and if they are taken on by one of the six other renal units in the region that unit will have to find the resources to treat them. The region will, incidentally, fail to meet a nationally agreed target for treated cases.

Consequences for the medical school and the community

Medical students cannot be taught properly without being able to see patients. They need to see patients with common diseases as well as those with rare conditions requiring specialist treatment so that they can better understand what medicine has to offer. Cuts in hospital workload must therefore be detrimental when, as at present, they are a consequence not of planned changes in services but of financial stringency. One suggested remedy is to disperse medical students widely to district hospitals. This would provide them with valuable practical experience. It makes no sense, however, haphazardly to run down the activities of institutions that are willing and able to offer students a combination of district general hospital and specialised clinical facilities in a complex intimately linked with a university where basic scientific disciplines are housed. Medicine's rapid rate of change means that the practical aspects of training must be balanced by a sound basic scientific training. In today's NHS standards of training are in serious peril.

Large cuts in hospital services are the consequences of demands from politicians and management for efficiency savings. Those locally responsible for implementing these cuts realise that they are detrimental and naturally delay them as long as possible. Inevitably, one district's forced and unplanned cuts push its neighbours into forced, unplanned overspending. Chaos will be the outcome, and our people deserve better than that.

Cuts in Birmingham Central Health Authority

Policy	Consequences
<i>General Hospital*</i>	
Dermatology: close four beds	Waiting time rises from five to seven weeks
General medicine: reduce one (medical) ward to five day working	Smaller emergency intake. Reduced working efficiency
General medicine: reduce another ward by 10 beds	Loss of 10 general medical† and surgical teaching cases
Pharmacy, physiotherapy, and dietetic departments: freeze on recruiting staff without reduction in workload	Worsening services
<i>Queen Elizabeth Hospital</i>	
Available beds reduced by 146 from 572 to 426; as only 498 beds are in use the fresh reduction amounts to 72 beds	Services reduced by 10% irrespective of need
All potential candidates for chronic ambulatory peritoneal dialysis refused until programme matches funding	Services reduced by at least 50%, preventing regional dialysis programme from matching its target

*All these measures are intended to save £161 000 in a year.

†Since East Birmingham Hospital unilaterally reduced its workload by closing two wards in 1986 medical admissions have risen at the General Hospital. The new policy will curtail this change. Ninety nine per cent of medical admissions are acute emergencies and it is unclear where the admissions will now go.